Staff/Household Member Health Examination Form

TO BE COMPLETED BY STAFF		
Patient's Name:		Date of Birth:
Patient's Address:	City:	Zip:
Patient's Signature:		Date:

TO BE COMPLETED BY HEALTH CARE PROVIDER
The above-named patient is a staff member or resident of a registered family child care provider in the state of New Jersey. New Jersey State regulations require a physician's statement verifying the individual is in good health, free from communicable disease and able to care properly for children placed in the home. The children enrolled in this program may include children from birth to 13 years of age. To assist us in evaluating the application, we are asking you to answer the questions below to the best of your knowledge.
Date of Physical Examination:
Is the patient in sufficient physical health to properly care for children? ☐Yes ☐No Remarks:
Is the patient is the free of communicable disease? ☐Yes ☐No Remarks:
Are you aware of any reason that the patient should not be left unsupervised with enrolled children, which may include children from birth to 13 years of age? ☐Yes ☐No If yes, please explain:
A Mantoux tuberculin skin test with five TU (tuberculin units) of PPD tuberculin is required and should be conducted within six months immediately preceding the submission of the application. A chest x-ray is required if the individual has had a previous positive Mantoux test or has a medical contraindication that precludes a Mantoux test. If the Mantoux tuberculin test result is insignificant (zero to nine millimeters (mm) of induration), no further testing shall be required. If the Mantoux tuberculin skin test result is significant (10 or more mm of induration), the individual shall have a chest x-ray taken. If the chest x-ray shows significant results, the staff member shall not come in contact with the children unless he or she submits to the center a written statement from a health care provider certifying that he or she poses no threat of tuberculosis contagion.

Date of Mantuox Test:	Results:	Date of Chest X-ray:	Results:

Physician Signature:	Date:	Physician Name:
Physician Office Address and Telephone:		

Clear Form